Division of women and children

Induction of labour

Information for women and their families

Introduction

This leaflet provides information about induction of labour. We hope it answers some of the questions you or those who care for you may have. This leaflet is not meant to replace the discussion between you and your healthcare team but aims to help you understand more about what is discussed. If you have any further questions please do not hesitate to speak to your healthcare team.

What is induction of labour and why am I being offered it?

Induction of labour (IOL) is a process used to start labour. In the UK, about 20 per cent of women have their labour induced. There are many reasons why you might be offered an IOL. The most common is going past your due date.

At 37 weeks, the risk of stillbirth is 1 in 3000 pregnancies. This increases to 3 in 3000 at 41-42 weeks and 6 in 3000 after 42 weeks. Also, your risk of the baby passing meconium (opening bowels) in the womb is higher after 42 weeks, which can cause complications including a higher risk of caesarean section.

Other reasons for IOL include:

- maternal age over 40 years (where the stillbirth risk at 40 weeks is similar to that at 42 weeks in mums under the age of 40)
- medical conditions, such as high blood pressure, diabetes, etc.
- twins

The timing of your induction will greatly depend on the reason you're having it.

Can I help myself go into labour naturally before my IOL date?

You can have a membrane sweep, which is an internal examination. The midwife/doctor will stretch your cervix (neck of the womb) and stimulate your body's natural labour hormones. Being mobile and active will also prepare your body for labour. Other commonly used methods include:

- raspberry leaf tea
- sex (not advised if you have a low placenta or your waters have broken)
- curry
- nipple stimulation
- acupuncture
- fresh pineapple

Please note there is limited research evidence to show that these methods work.

How will I be induced?

We will monitor your baby's heartbeat for 30 minutes and then perform a vaginal examination to assess your cervix. This helps us decide which of the following methods of induction is best for you:

1) **Softening and shortening of your cervix** (cervical ripening) by inserting the 'labour hormone' medication into the vagina
2) **Breaking the waters around your baby** (artificial rupture of membrane - ARM)
3) **Using an intravenous oxytocin drip** (syntocinon) to enhance the contractions and open your cervix

We use three types of 'labour hormone' medication for vaginal insertion. The type we recommend depends primarily on the reason for your IOL and other factors such as how many weeks pregnant you are, how soft and open your cervix is and how many babies you have had previously. If you are concerned about the choice of medication, or you have strong feelings about having a particular type of medication, please speak to your doctor. We are happy to create an individualised plan for you.

- **Mysodelle® pessary (200 micrograms of Misoprostol)** it looks like a little tampon and once in place, you can walk around, shower, eat and drink normally. It stays in place for 24 hours before removal (unless you go into labour). Its main advantage is that it works faster (trial evidence showed 11 hours faster total induction time) and is therefore suitable for inpatient IOL
- **Propess® pessary (10 milligrams of Dinoprostone)** is also like a little tampon and is put in your vagina. The pessary slowly releases prostaglandins (labour hormone) and prepares the neck of the womb for labour. Once the pessary is in place you can walk around, shower, eat and drink normally. It is left for 24 hours before it is removed. It is suitable for both outpatient and inpatient IOL
- **Prostin® (1 or 2 milligrams of Dinoprostone)** gel also prepares the neck of the womb for labour. You may need to use it more than once. There must be at least a six-hour period between each application of the gel but this period may be longer if you are having contractions or if the labour ward is very busy

After you have been given the medication:

- you may go into labour
- your waters may break without you being in labour
- the neck of your womb may soften and shorten but you may not have gone into labour. If this happens, your waters will need to be broken and then you will need an oxytocin drip to start your contractions

Artificial rupture of membranes (ARM) 'breaking the waters'

ARM can be performed if the cervix has started to dilate (open). A small hole is made in the membranes using a slim, sterile, plastic instrument during a vaginal examination. Having your membranes broken should help to stimulate your contractions.

Use of oxytocin (syntocinon)
Sometimes prostaglandins or breaking the waters is enough to start labour but many women require syntocinon (artificial oxytocin), which is given through a drip into a vein in the arm to bring on strong, regular contractions.

It is important to monitor the baby's heartbeat and your contractions continuously, with a monitor that is usually attached to you with elastic straps, while using the oxytocin drip. The contractions can feel stronger when the drip is used.

Balloon catheters
A balloon catheter is usually offered to women who have previously had a caesarean section. The doctor places the balloon through the cervix and inflates it with 20 millilitres of water. The balloon is the size of an apricot and sits above the cervix, stimulating your body's natural labour hormones to be released, dilating the cervix.

Can I go home during the induction?

Women who are being induced for postdates (41+3-41+6) will be encouraged to have an outpatient induction if there aren't any other risk factors. This means that you would go home for the first 24 hours of the induction (called the propess phase).

The benefits of outpatient induction of labour:

- being in your own home environment rather than in hospital
- research has shown that women cope with the early labour (latent labour) period better at home, and that a comfortable environment encourages progress into active labour[1]
- women who have outpatient induction report a better birth experience [2,3]

When you arrive for outpatient IOL:

- a midwife will put the baby's heartbeat monitor on to assess your baby's heart rate
- a doctor will perform an ultrasound scan to check the level of fluid around your baby (if it is low, we might ask you to stay in hospital instead of going home)
- a midwife with insert a Propess® pessary into your vagina
- we will monitor you again for around 45 minutes

After this you can go home. A midwife will call you that evening to see how you are doing. They will advise you to attend the labour ward 24 hours after the pessary has been inserted to continue your induction of labour.

For safety reasons, you will need to:

- have access to a telephone at home
- be accompanied by an English-speaking adult at all times while at home (if needed)
- be able to come into hospital if you go into labour, break your waters, or have any worries about your baby

How long will IOL take?

It is different for each woman and depends on how ready the neck of your womb is for birth. In general, it may take two or three days from the start of the IOL to your baby being born.

What are the risks involved with induction of labour?

Over-contracting of the womb may occur with either prostaglandins or oxytocin. If Propess® or Mysodelle® is being used then this will be removed. If the oxytocin drip is being used then this will either be turned down or off until contractions return to a normal rate. We can give you medication to reduce the contractions if needed.

If IOL is recommended for a clinical reason (such as blood pressure problems, diabetes, having a small baby, or going over 41 weeks), your risk of caesarean section is not increased when compared to other women with the same condition.[4,5] We do not generally recommend IOL at 37-39 weeks unless there are clinical concerns due to the slightly increased risk for babies in terms of brain and lung development, compared with similar babies born at 39-41 weeks.[6]

The main disadvantage of IOL is a woman's experience of the labour process, with lower birth satisfaction scores when compared to spontaneously labouring women. For these reasons, we only recommend an IOL when there are clinical risks, such as blood pressure, diabetes, etc.[7]

What pain relief can I have?

All the usual pain relief options can be used during IOL. The early labour pain can last for a longer time and you may want to rent or buy a TENS (transcutaneous electrical nerve stimulation) machine to help you with this period. This is a small, battery-operated device with leads that connect to sticky pads that are placed on your back. It is a safe and effective form of pain relief for women in the early stages of labour. We also offer women early epidurals if they need the syntocinon drip. Please note that while we try our hardest to provide epidurals for women in pain as soon as they make a request, an epidural procedure may sometimes be delayed if:

- the anaesthetic doctor is busy in the operating theatre attending an emergency case
- blood tests and other preparations are needed first, to make the procedure safe for you

What happens if induction does not work?

If you do not go into labour with prostaglandin/balloon/syntocinon drip, your midwife and obstetrician will discuss your options with you and check you and your baby thoroughly. Depending on your wishes and circumstances, we may offer you:

- a caesarean delivery
- the option to stop the IOL and try again after a break (the next day or later, if appropriate)

Can I still have a home birth or go to the birth centre?

If your labour is induced, national guidance (NICE) recommends you have your baby in a consultant-led labour ward.

What happens if I choose not to be induced?

Your obstetrician or midwife will explain why they recommend induction of labour, but it is your choice whether or not to go ahead. If you choose not to be induced, we can arrange for you to have regular checks of your baby's heartbeat and may offer you a scan to check the amount of fluid around the baby. However, these checks cannot predict how your placenta will continue to work and complications may still occur.

Why might my induction be delayed?

We understand that it can be upsetting and distressing to have your induction delayed. Occasionally, the unit can become very busy with women arriving in labour or needing urgent care. We always prioritise our workload accordingly and work within the interests of safety. In these circumstances, we might:

- offer you the IOL at another Imperial College Healthcare NHS Trust site
- rebook your IOL for a different day (if appropriate)
- ask you to wait in the antenatal ward, with regular checks for you and your baby, until we can start/continue your IOL

If you have any questions at any time please speak to the senior midwife on duty.

Where do I go for my induction?

For **Queen Charlotte's & Chelsea Hospital:**

- if you are having an outpatient IOL, come to the day assessment unit (ground floor, behind the antenatal clinic) at 07.00 (weekdays) and 10.00 (weekends)
- if you are booked for Lewis Suite, phone the ward on 020 3313 3349 at 07.00. The staff will advise what time is best to come in, depending on the bed status and staffing numbers for the day. The Lewis Suite is located on the first floor of Hammersmith Hospital (opposite the birth centre)
- if you are booked for the labour ward, phone the labour ward coordinator at 11.00 on the day of your induction on 020 3313 5167 or 020 3313 8955. They will advise you of the best time to come in to the ward on that day as it is dependent on staffing and workload

For **St Mary's Hospital:**

- come to triage on the labour ward (first floor, Clarence memorial wing) at 08.00
- if you are having an outpatient IOL, you will be sent home from there. If you are staying in hospital, we will transfer you to Alec Bourne 2 ward after you have been given your induction agent and the usual checks have been carried out

Who should I contact if I have more questions?

Please watch this video produced by our colleagues at MedNav for more information: www.youtube.com/watch?v=AdRC8nGqwbs (alternatively, search YouTube for "New Futures Induction of Labour" and pick the video made by "NewFutures CW+").

We are also holding group education sessions on induction of labour. To book your place, please phone:

Queen Charlotte's & Chelsea Hospital's day assessment unit: 020 3313 5195

St Mary's Hospital's day care unit: 020 3312 7707

You can attend information sessions at either site.

How do I make a comment about my visit?

We aim to provide the best possible service and staff will be happy to answer any of the questions you may have. If you have any **suggestions** or **comments** about your visit, please either speak to a member of staff or contact the patient advice and liaison service (**PALS**) on **020 3313 0088** (Hammersmith and Queen Charlotte's and Chelsea hospitals), or **020 3312 7777** (St Mary's Hospital). You can also email PALS at imperial.pals@nhs.net. Alternatively, you may wish to express your concerns in **writing** to: complaints department, fourth floor, Salton House, St Mary's Hospital, Praed Street, London W2 1NY.

This leaflet can be provided on request in large print, as a sound recording, in Braille, or in alternative languages. Please contact the communications team on 020 3312 5592.

We have a free wi-fi service for basic filtered browsing and a premium wi-fi service (requiring payment) at each of our five hospitals. Look for WiFiSPARK_FREE or WiFiSPARK_PREMIUM

References

1. Bailit et al. 2005; Klein et al. 2004; Holmes et al. 2001; McNiven 1998).
2. Biem SR, Turnell RW, Olatunbosun O, Tauh M, Biem HJ. A randomized controlled trial of outpatient versus inpatient labour induction with vaginal controlled-release prostaglandin-E2: Effectiveness and satisfaction. *J Obstet Gynaecol Can*. 2003;25(1):23-31.
3. O'Brien E, Rauf Z, Alfirevic Z, Lavender T. Women's experiences of outpatient induction of labour with remote continuous monitoring. Midwifery. 2012.
4. Little SE, Caughey AB. Induction of labor and cesarean: what is the true relationship?. Clinical obstetrics and gynecology. 2015 Jun 1;58(2):269-81.
5. Stock SJ, Ferguson E, Duffy A, Ford I, Chalmers J, Norman JE. Outcomes of elective induction of labour compared with expectant management: population based study. Bmj. 2012 May 10;344:e2838.
6. Spong CY, Mercer BM, D'Alton M, Kilpatrick S, Blackwell S, Saade G. Timing of indicated late-preterm and early-term birth. Obstetrics and gynecology. 2011 Aug;118(2 Pt 1):323.
7. Dencker A, Taft C, Bergqvist L, Lilja H, Berg M. Childbirth experience questionnaire (CEQ): development and evaluation of a multidimensional instrument. BMC pregnancy and childbirth. 2010 Dec 10;10(1):81.

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